Health Services
LOS ANGELES COUNTY

January 15, 2013

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

TO: Each Supervisor

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STEPS REQUIRED TO SUCCESSFULLY ADAPT THE DEPARTMENT OF HEALTH SERVICES AND LOS ANGELES COUNTY FOR THE AFFORDABLE CARE ACT (Agenda Item #39, January 15, 2013)**

UPDATE

Beginning with the Governor's budget release on Thursday, January 10, 2013, the Legislature will debate and negotiate with the Governor on a wide range of important policy and budgetary issues including determining the approach to Medicaid expansion, whether the State will create a Basic Health Plan (BHP), what level of benefits the California Health Exchange will offer to which populations, and how to fund medical care for the millions of Californians who will remain uninsured after full implementation of the ACA. Depending on how the proposals take shape, we will regularly seek Board direction on the County's position, as well as how to optimize our strategy based on the evolving policy and regulatory environment.

Regardless of how these issues are resolved, DHS can and must continue to move ahead to deliver more care services at a higher level of quality at a decreased cost. This strategy is our best chance of success in any reimbursement environment. A high-level description of our strategy for health reform, based on my prior presentation to the Board, is included as an Appendix with this update (Attachment 1). DHS, our community partners (CPs), our sister County departments, and numerous other partners are deeply engaged in implementing our health reform strategy. In this and future updates, I will focus on external and internal policy, finance, and operational related developments.

POLICY DEVELOPMENTS

Medicaid Expansion

Under the ACA, the federal government will cover 100% of the costs of the newly eligible Medicaid beneficiaries through the year 2016. In later years, the federal matching rate will decline to 90 percent from 2020 onwards. Although this percentage is relatively smaller, and significantly higher than the regular Medicaid matching rate for the entire state, 10% of the cost is a very large number (estimated at $300 to $400 million annually). Until recently, a persisting policy uncertainty that had

significant implications for coverage access under the Medicaid expansion was whether States could expand Medicaid only partially — i.e. not all the way to 133% of the Federal Poverty Level (FPL) — and still get the full federal payment. On December 10, 2012, the United States Department of Health & Human Services (HHS) clarified that the ACA requires states to fully expand Medicaid to the 133% income ceiling in order to receive the 100% federal matching rate. Therefore, California cannot expand Medicaid to a lower ceiling (e.g. 100%) and still receive the full 100%, as opposed to the existing 50% match rate.

In his 2013-14 budget proposal, the Governor describes Medicaid expansion as having a mandatory and an optional component. The mandatory component requires simplifying rules affecting eligibility, enrollment, and retention for currently eligible Medi-Cal individuals. For costs related to this mandatory component, the budget allocates an additional $350 million in General Funds. The optional component refers to Medi-Cal expansion for childless adults under 138% FPL. The Governor proposed two approaches to a Medicaid expansion:

- ***State-based approach:*** Building upon the existing state-administered Medicaid program and managed care delivery system, the state would offer a standardized, statewide benefit package comparable to that available today in Medi-Cal, but would exclude long-term care coverage (for long-term care, the person would apply for benefits under the traditional Medicaid program). .

- ***County-based approach:*** Building upon the existing LIHP, counties would meet state-wide eligibility and minimum health benefit requirements and act as the fiscal and operational entity responsible for the expansion.

The Governor was clear that the State-based approach would require that the counties contribute realignment money upfront. Although the Medicaid expansion is 100% paid for by the federal government, the State anticipates administrative costs to the expansion and increased costs to traditional Medicaid based on a growing caseload with increased outreach to enroll uninsured persons.

We anticipate that it would be challenging to gain federal approval for the county-based approach given that the ACA anticipates a nationwide approach to increasing insurance coverage. It would also complicate enrollment for low income people (e.g. their children would be enrolled in State-wide Medicaid while they would be enrolled in a county Medicaid program; women who became pregnant would switch programs at the time of pregnancy).

Improving Coverage Affordability

Under the ACA, individuals with income within 133%-400% FPL will be eligible to seek health insurance through a health insurance exchange. On January 3, 2013, 'Covered California', California's exchange, received federal approval to establish a health care marketplace. Insurance coverage obtained through an exchange will be subsidized, so that many people who could not previously afford insurance will be able to obtain coverage. Unfortunately, even with the subsidies provided through the exchange, coverage will still be too expensive for those who hover just above the poverty line, particularly within income between 133%-200% FPL. In addition to affordability, another potential problem is churn

between the Medicaid program and coverage through the exchange. Due to income fluctuations related to changes in employment and family structure, individuals within this income group are likely to find themselves cycling between Medicaid eligibility and eligibility for subsidies on the exchange, potentially resulting in disruptions in care. This is why Congress purposefully included in the ACA an option for states to create a Basic Health Plan (BHP) for working people with incomes within 133-200% FPL. Through a BHP, states can achieve a more affordable price-point by reducing administrative costs and leveraging existing health networks with experience serving lower-income populations. DHS supports the creation of a BHP, as it would enable the patients we serve to obtain affordable coverage and preserve continuity of care. The state legislature's special session on health care reform may take up the issue for consideration. Unfortunately there are no federal regulations currently promulgated regarding the BHP, which at a minimum would mean that a BHP could not be operational in 2014.

Another proposal to improve affordability and continuity of care for this patient population will be considered by Covered California's Board on January 17, 2013. In the Governor's budget proposal, the Administration, in partnership with Covered California, is proposing to establish a Medicaid Bridge Program. Using selective contracting processes, Covered California would negotiate contracts with Medi-Cal Managed Care plans that have robust safety net provider networks to offer a plan option on the Exchange with a very low or zero premium for those earning between 133% and 200% FPL. The briefing document for this proposal is included with this update (Attachment 2).

FINANCE DEVELOPMENTS

DHS Projections for FY 2014-15

Utilizing the best available data along with a range of assumptions for the policy uncertainties, DHS Finance is in the process of providing the Board with several different projections of the DHS budget for Fiscal Year 2014-15. Because Fiscal Year 2013-14 will consist of half old financing and half new financing, we will use the Fiscal Year 2014-15 as our base case. We anticipate reporting our projections to the Board on February, 19, 2013.

Enrollment in HWLA

If California chooses to expand Medicaid under the ACA, we will work closely with state and federal agencies to ensure a smooth transition of our HWLA patients into Medi-Cal, preserving patient-provider relationships and avoiding unnecessary disruptions in care. As of the close of Calendar Year 2012, HWLA enrollment approached 215,000 individuals, with approximately 140,000 assigned to DHS medical homes and 75,000 assigned to CPs. Our goal is to enroll over 300,000 individuals by the end of 2013. Personnel at DHS, DPSS, DMH, CPs and numerous other partners are working diligently to enroll new members and improve redetermination rates for existing members. On January 15, 2013, Everyone on Board" will be officially launched, which is a multi-partner campaign involving coordinated outreach and enrollment activities that will not only strengthen processes in traditional clinical settings, but will also meaningfully extend outreach and enrollment to numerous other community-based venues such as parishes, college campuses and "employment centers. The campaign includes the production of high quality outreach materials and training of over one hundred certified application assistants, promotoras and community health workers to become HWLA enrollers in community-based settings.

Annual redetermination (renewal) of HWLA eligibility for our enrollees has proven challenging. As HWLA enrollees approached their one year tenure in the program, enrollees were required to appear in-person to complete the redetermination process. Many HWLA participants were unable or unwilling to return to their clinic to complete the in-person process. To address this challenge, DHS in partnership with DPSS has created a new HWLA Redetermination Mail-in Unit. The unit enables patients to complete the redetermination process by mail, similar to the process that Medi-Cal utilizes for redetermination. The unit will oversee all 2013 HWLA redeterminations and began operations on January 7, 2013. The unit is staffed by DPSS eligibility workers, who will leverage their earlier experience and expertise with Medi-Cal mail-in redeterminations in which they achieve a 75% redetermination rate. In addition, the Department has applied for a grant to provide proactive outreach calls to those patients who are due to redetermine in the following month, as well as outreach to those patients who have lost coverage due to failure to redetermine.

Integrating the Safety-Net System

DHS is also making progress on ensuring continuity of specialty care for patients who utilize CPs for primary care but also rely on DHS for specialty care services. In December 2012, DHS was awarded $200,000 from the Blue Shield Foundation to help develop the necessary fiscal, contractual and referral mechanisms for DHS specialty care providers to be in the provider network of Independent Practice Associations (IPAs), such as Health Care LA and AltaMed.

HEALTH CARE REFORM IMPLEMENTATION TASKFORCE

The Chief Executive Office's (CEO) Health Care Reform Implementation Task Force had its first meeting on December 11, 2012, in which five County departments came together to begin identifying our collective strategic goals. A list of the department goals will be sent in a separate CEO memo.

CONCLUSION

The next two to three months are likely to include a lot of intense jockeying between the Governor's Administration and the Legislature. We will seek your advice and help in responding to these and other policy initiatives as they are released. Meanwhile I believe that DHS, our CPs, and sister County Departments are making steady progress to prepare for health reform. I look forward to reporting on our further progress next month.

If you have any questions or need additional information, please contact me or Anish Mahajan, Director of System Planning at (213) 240-8416.

MHK:jp

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

Department of Health Services (DHS) Strategy for Health Reform
January 2013

This document is a high-level description of the DHS strategy for adapting to the challenges presented by health reform. Strategic goals for DHS system improvement and the healthcare business environment are listed for the three major challenges that health reform presents to DHS operations. This document will be regularly updated to reflect federal and state policy and budgetary decisions that would impact our operations and the broader healthcare marketplace in the Los Angeles County.

Major challenges of health reform to DHS

- Patient choose to leave our system
- Capitation/bundled payments are lower than actual expenses
- Funds for uninsured patients (Federal DSH and State Realignment) drop

DHS System Improvement Goals to address challenges

- Challenge: Insured patients choose to leave DHS
  - Better customer service
  - Strengthen patient-provider relationship
  - Improve access to appropriate specialty care
  - Increase primary care capacity

- Challenge: Partner health plans choose to assign fewer lives to DHS
  - Better customer service
  - Improve performance on HEDIS measures

- Challenge: DHS expenses exceed capitation revenue
  - Higher clinical productivity
  - Reduce unnecessary admissions
  - Reduce admin/denied bed days
  - Reduce use of contract providers/registry staff wherever possible
  - Increase enrollment and retention in HWLA
  - Reduce out-of-network use of by assigned lives
  - Improve efficiency of operations
    - Better IT (EHR, Disease Management Registry (i2i), eConsult, Enterprise Patient Data Repository (EPDR), etc.)
    - Organizational restructuring to optimize economies of scale (HIM Dept, centralized nursing)

- Challenge: Funds for uninsured patients drop
  - Develop empanelment model to increase efficiency of care for residually uninsured
  - Community Partner payment reform

DHS Business Goals to address challenges

- Challenge: DHS expenses exceed revenue
  - Be assigned dual-eligible lives through pilot
  - Develop contracts with IPAs to serve as specialty/hospital care referral center
  - Develop contracts with health plans for selected specialty services (acute rehab, burn unit)
  - Obtain 340-B pricing for meds dispensed from ambulatory care centers
  - Optimize future University affiliation agreements (MSAAs) by including productivity and quality expectations

DHS Partnership Goals with County CEO/Sister Departments to address challenges

(See separate materials from CEO's Task Force on Health Reform entitled "Goals and Priorities of Participating Departments")